

# TESTING HEALTH CARE WORKERS AND PATIENTS FOR AIDS/HIV: CONFLICTS BETWEEN STATE AND FEDERAL POLICIES

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## I. INTRODUCTION<sup>1</sup>

### A. *Historical Overview*

Beginning in 1983, legal policies<sup>2</sup> addressing the myriad of social, economic, political and medical concerns confronting U.S. American society as it battles with the onslaught of the HTV and AIDS pandemic have undergone constant evolution.<sup>3</sup> No more dramatic an example of that process

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<sup>3</sup>This paper is an abstract and, therefore, a derivative work of a lengthier research article (unpublished) and has been prepared specifically for the 1992 Annual Meeting of the Southeastern Academy for Legal Studies in Business, Jacksonville, Florida. Authors reserve all applicable copyright protections.

<sup>2</sup>For early applications of legal issues involving AIDS, see SPENCER, Fane, BRITT & BROWNE (law firm) Hospital Law Manual AIDS & Hospitals The Emerging Legal Issues (1986). Another important early work is Arthur S. Leonard, *Employment Discrimination against Persons with AIDS*, 10 U. Dayton L Rev. 681 (1985).

For a recent book with very thorough coverage about the legal issues of AIDS, see WILEY LAW Pubs. Ed. STAFF, AIDS And THE LAW (2d ed. 1992). For comparisons of current global policies, see volume 23, *Symposium on International and Comparative AIDS Policy*, N.Y.U.J. INTL L & POL.

<sup>3</sup>D C Jcyasunyz, *AIDS-Related Legislation in the Context of the Third AIDS Pandemic*, 18 LAW, MED. & HEALTH CARE 41, a 1 (1990) (Jayasuriya discusses world-wide stigmatization and quotes Javier Perez de Cuellar, former United Nations Secretary, about the concerns in addition to the medical ones that accompany any epidemic like AIDS, which has been termed the "Third Pandemic").

AIDS raises crucial social, humanitarian, and legal issues threatening to undermine the fabric of tolerance and understanding upon which our societies function."

*Id.* at 41 (quoting J. Mann, Statement at an Informal Briefing on AIDS to the 42d Session of the

can be found than in an examination of the policies that local school boards initially used to deny HTV/AIDS afflicted children access to school.<sup>4</sup>

Originally, and as it is now, the fear of contact with people infected with HTV is the product of a lack of knowledge as to how the virus is contracted.<sup>5</sup> Those fears were especially heightened amongst parents concerned that casual contact with another child infected with HTV would constitute a serious threat to their offspring's health.<sup>6</sup> Eventually, the results of intensive medical research, increased public awareness as to the methods of transmission of HTV, and new federal laws brought an end to the debate over the rights of HIV infected children to attend school.<sup>7</sup>

At the same time that public policy makers were wrestling with the impact of HIV on the school system, other significant issues routinely began to emerge. Attention gradually began to shift away from the classroom and to focus on the health care delivery system. It soon became apparent that health care workers (HCWs)<sup>8</sup> are at risk of infection when providing medical services. Incidents such as the infection of one New York physician who accidentally contracted the virus through a needle left carelessly in a bundle of soiled bedding, left little doubt that HCWs are at no small risk of HTV infection.<sup>9</sup> But the general public's attention to the dangers that HTV presented in the health care delivery setting did not become acute until the case of Kimberly Bergalis received widespread attention.<sup>10</sup> Ms. Bergalis was

United Nations General Assembly, Oct. 20, 1987).

4. See, generally, Joseph Kelly, *The AIDS Virus in the Workplace: A Comparison of British and American Law Concerning the HIV-Infected Employee*, 37 MED. TRIAL TECH. Q. 184, at 189 (1990).

5. See, e.g., Cronon v. N.E. Tele. Co., 41 Fair Empl. Prac. Cas. (BNA) 1273 (1986) (employee threatened by a lynching mob after co-workers discovered he was HTV+).

6. For example, see, *The New Untouchables*, TIME, Sept. 23, 1985, 24-26 (early hysteria about HIV+ school children and gays).

7. Sharon Rennert, *AIDS/HIV and Confidentiality: Model Policy and Procedures* 84-84, nn. 59-65 (1991). See generally, Thomas T. Noguchi & Edward C. KIMI, *AIDS and Forensic Medicine: The Impact of the AIDS Epidemic on the Medical and Legal Professions*, in LEGAL MEDICINE 73, AT 76 (C. Wecht ed. 1991).

8. There are varying meanings of the term Health Care Workers (HCWs). Scott H. Isaacman, *The Other Side of the Coin: HIV-Infected Health Care Workers*, 9 ST. LOUIS U. PUB. L. REV. 439, at a 2 (1990). Isaacman distinguishes between HCWs, who have substantial contact with patients, and those, such as janitors, who do not. *Id.* 439-40, at a 3. In one Texas statute, a HCW is defined to be "a person who furnishes health care services in direct patient care situations." TEX. HEALTH & SAFETY CODE ANN. sec. 85.201(2) (Vernon Supp. 1992).

9. *Veronica Prego v. City of New York*, 147 AD.2d 165, 541 N.Y.S.2d 995 (1989), *in*, David W. Webber, *AIDS in the Workplace*, in AIDS AND THE LAW 87, at 180 (2d ed. 1992). The 32-year old doctor sued the hospital and two physicians for \$175 million and settled for \$7 million. Bernard J. Ficarra, *Physicians' Legal and Moral Responsibility to Treat Contagious Diseases*, in LEGAL MEDICINE 1991, *supra* note 8, at 98-99 (citing L. Goodstein, *Physician with AIDS Takes Her Case to Trial*, The Wash. Post, Jan. 7, 1990, at 7).

10. Donald J. McNeil & Laurie A. Spieler, *Mandatory Testing of Hospital Employees Exposed to the AIDS Virus: Need to Know or Unwarranted Invasion of Privacy?* 21 LOY. U. CHL. L.J. 1039, 1046, n. 55 (1990) (the Bergalis incident was reported by the CDC on July 27, 1990).

apparently infected with HTV by her Florida dentist with AIDS, while undergoing routine dental treatment in his office.

Public concerns about the safety of the health care delivery system were magnified with the report that a physician at one prestigious medical center had treated over 1800 patients before his death from AIDS.<sup>11</sup> Attempts to identify, notify, and test the doctor's former patients raised new questions amongst the policy makers and the public concerning possible infection by HCWs.

As a result of these concerns, the ADA,<sup>12</sup> the AMA,<sup>13</sup> and the CDC<sup>14</sup> adopted new policies designed to protect patients against the risk of HTV infection from HCWs and to restore the public's confidence in the health care delivery system. Seemingly forgotten in the quest to calm the public were the rights of HCWs and patients, alike.<sup>15</sup>

Employers have not been immune from the economic consequences of society's war against AIDS.<sup>16</sup> Staggering costs associated with treating persons with AIDS in an environment wherein employers have been subject to skyrocketing employee health insurance premiums have led to the discriminatory treatment of employees with AIDS in the area of health insurance benefits.<sup>17</sup>

Rather than being a regional problem, the extent of HTV infection is a global problem which is transmitted across boundary lines as easily as people

11. Mark Barnes, Nicholas A Rango, Gary R. Burke, Linda Chiarello, *The HIV-Infected Health Care Professional: Employment Policies and Public Health*, 18 LAW, MED. & HEALTH CARE 311, n. 3 (1990).

<sup>12</sup>The American Dental Association issued a policy statement in 1991 that HTV-infected dentists should refrain from performing invasive procedures or should disclose their seropositive status. Noguchi & Klatt, *supra* note 7, at 77 (citing Barbara Gerbert, Thomas Bleeker, Cara Miyasaki & Bryan T. Maguire, *Possible Health Care Professional-To-Patient HIV Transmission*, 265 JAMA 1845-8 (1991)).

<sup>13</sup>The AMA Board stated that physicians who are at risk in acquiring HTV from high-risk behavior and who perform invasive procedures ought to be tested. Noguchi & Klatt, *supra* note 7, at 77 (citing Statement of the AMA Board of Trustees, Jan. 17, 1991).

14. CDC, *Recommendations for Preventing Transmission of Human Immunodeficiency Virus and Hepatitis B Virus to Patients During Exposure-Prone Invasive Procedures*, 40 MMWR 1-8 & Appendix (July 12, 1991) [hereinafter referred to as *1991 CDC Guidelines*].

15. Jane Gross, *Many Doctors Infected With AIDS Don't Follow New U.S. Guidelines*: N.Y. TIMES, Aug. 18, 1991, at 1 col. 1; Dennis Hevesi, *Fury and Relief Greet AIDS Proposal*, N.Y. TIMES (Metro.), Oct. 9, 1991, at B6.

<sup>16</sup>See, e.g., Christine Woobey, *AIDS Claims Hit \$1 Billion. ■ Group Health Insurance Insurer Pay Bulk*, 24 BUS. INS. 2 & 38 (1990); Rory Judd Albert & Neal S. Schelberg, *AIDS Has Damaging Effects on Employee Health Plans*, 28 PENSION WORLD 52-54 (1992) (discussing lost productivity costs).

<sup>17</sup>In *McGann v. H & H Music Co.*, 946 F.2d 401 (5th Cir. 1991) *petition for cert filed sub nom. Greenburg v. H & H Music* (US. Sup. a. 91-1283), *cert denied* The Fifth Circuit ruled that ERISA does not prevent an employer from limiting health benefits to an AIDS affected employee, despite prejudice against employee). *Accord, Owens v. Storehouse, Inc.*, 773 F.Supp. 416 (D.Ga. 1991).

travel from country to country in this modern world. Attempts to contain the spread of the virus have added to the conflicting humanitarian interests, including the issue of admitting HTV+/AIDS immigrants into the United States.<sup>18</sup> Most courts and legislatures responded quickly by defining HTV+ workers as a protected class.<sup>19</sup> Well-meaning attempts by the legislatures and the judiciary to combat discriminatory acts against HIV/AIDS afflicted people continue.<sup>20</sup> However, the multitude of legal declarations have been on a course of inevitable collision, given the mutually exclusive classifications of workers versus employers and patients versus HCWs.

It is within this turbulent environment of change that a significant number of individuals find themselves often in conflicting roles. One can easily be the victim of the onslaught of the HIV virus, while at the same time trying to occupy the roles of patient, HCW, and employee. Such a juxtaposition of conflicting roles necessarily must lead to a clash of competing interests that ultimately find their way into the letter of the law. Not the least of those conflicts is the goal of providing the general public with a health care delivery system that is safe and in which society has a high level of confidence while at the same time respecting patients' and HCWs' rights to confidentiality and privacy.<sup>21</sup> The authors' goals are to examine the conflicts between privacy, confidentiality, and attempts to contain the HTV virus in the health care setting.

<sup>18</sup>Ficarra, *supra* note 9, 106-07 (blasting the U.S. Dep't HHS inconsistent policy decision on January 4, 1991 to allow persons with AIDS and leprosy and syphilis and gonorrhea to enter the U.S. for purposes of immigration, as opposed to travel).

<sup>19</sup>*E.g.*, *Cronon v. N.E. Tele. Co.*, *Shuttleworth v. Broward County*, 639 F.Supp. 654 (S.D. Fla. 1986). *Noguchi & Klatt*, *supra* note 7, at 76 (most states along with the federal laws prohibit discrimination against HTV+ in housing, employment, and education); *Webber*, *supra* note 9, at 93,100, n. 206, & nn. 235-236 (employers may be liable for their employees' discrimination against HIV+/AIDS persons, under Americans With Disabilities Act and the Rehabilitation Act, citing *Glanz v. Vemick*, 756 F.Supp. 632 (D. Mass. 1991); NATIONAL LAWYERS GUILD AIDS NETWORK, AIDS PRACTICE MANUAL App. B (3d ed. 1991) (state by state listing of the HIV/AIDS antidiscrimination statutes).

<sup>20</sup>*E.g.*, *Cain v. Hyatt Legal Servs.*, 734 F.Supp. 671 (E.D. P. 1990); *Benjamin R. v. Orion Exterminating Co.*, 390 S.E2d 814 (W.Va. 1990); *Club Swamp Annex v. White*, 561 N.Y.S.2d 609 (App. Div. 1990); *Raytheon Co. v. Fair Empl. & Housing Comm'n*, 212 Cal. App. 3d 1242, 261 Cal Rptr. 197 (1989). *See generally*, *Kelly*, *supra* note 4, 189, n. 16; *Noguchi & Klatt*, *supra* note 7, at 73; *Ficarra*, *supra* note 9, at 93 (citing additional numerous unpublished cases).

<sup>21</sup>There is a distinction between confidentiality and privacy. Confidentiality applies to records and privacy to the body. *Harold L. Hirsch, A Visitation With AIDS (Part VII)*, 37 MED. TRIAL Tech. Q. 1, 25 (1990). *See generally*, *Donald Mayer, Workplace Privacy and the Fourth Amendment: An End to Reasonable Expectations?*, 29 AB.L.J. 625(1991) (discussion of reduction on Fourth Amendment protections and employees' expectations of privacy).

*B. Conflicts In Federal Policies*

There are two (2) significant reasons for keeping one's HIV status a secret: the social stigma of being labelled a member of one of the high risk groups traditionally associated with the spread of AIDS,<sup>22</sup> and secondly, the potential loss of insurance coverage.<sup>23</sup> The U.S. is confronting a third reason for maintaining secrecy of one's HIV status; one that is certainly related to the first two reasons, but with a particular focus. It is the loss of privacy, confidentiality, and employment, specifically for HCWs.<sup>24</sup> The need to know one's seropositive status as a HCW can also conflict with the need of a patient to maintain his/her secret of being HIV infected.

The CDC in 1983 first identified HIV as a potential risk to HCWs.<sup>25</sup> In 1987, OSHA issued an advisory for HCWs and emphasized the need to use "universal precautions."<sup>26</sup> Thereafter, the focus shifted from protecting HCWs to protecting patients. Responding to this shift in focus, the CDC issued its July 12, 1991, Guidelines for protecting patients from possible HIV infection by HCWs.<sup>27</sup> These guidelines suggest that all HCWs should know their HIV (and Hepatitis B) status. If the HCW is positive, (s)he should either stop practicing "exposure-prone" "invasive procedures"<sup>28</sup> or else inform the patient and obtain patient consent to continue. If the HCW is HTV + and does not wish to stop working then (s)he should seek advice from an expert review panel, who will determine the extent of the procedures that the HCW can continue and the scope of consent needed from the patients, for "exposure- prone" procedures.<sup>29</sup>

<sup>22</sup>Jayasuriya, *supra* note 3, 42 (the stigma of AIDS lingers even after death on death certificates).

<sup>23</sup>See *supra* note 17.

<sup>24</sup>Ficarra, *supra* note 9, 106 (citing numerous examples, including the Charlotte Memorial Hospital that dismissed a HCW suffering from AIDS; a Virginia physician with AIDS awarded \$20,000.00 by his employer; a physician with AIDS at Cook County Hospital in Chicago was suspended and then reinstated); Kelly, *supra* note 4, 184 (citing additional examples of HCWs who are losing jobs); Barnes, *supra* note 11, 311.

<sup>25</sup>Webber, *supra* note 9, 85, a 171.

<sup>26</sup>Universal precautions are recommended for exposure to all bodily fluids and tissues even though not all are thought to be infectious. Webber, *supra* note 9, 87, at n. 184. OSHA's jurisdiction does not extend to U.S., states, or their political subdivision, although states and municipalities have parallel regulations. *Id.* 88-89, a 187, & a 189.

<sup>27</sup>1991 CDC Guidelines, *supra* note 14.

<sup>28</sup>1991 CDC Guidelines, *supra* note 14, Appendix, at 9. CDC defines "invasive procedures" to be a "surgical entry into tissues, cavities, or organs or repair of major traumatic injuries" and listing several situations in which these entries can occur, including, for example, a dentist office. *Id.*

<sup>29</sup>CDC also recommended that the "exposure-prone" procedures should be identified by the organizations and institution where the procedures are performed. *Id.* at 5. Subsequently, there was an attempt by CDC to propose a list of procedures that HIV+ HCWS should not perform. CDC retreated from the plan after much criticism because the risk of transmitting is almost zero and creating such a list would be inconsistent with its own policy statements. *See generally.*

There are several goals envisioned by the CDC Guidelines: (1) to assuage public fear, so as to re-instill public trust in the health care system (2) to not only sensitize HCWs for the need for infection control, but to also protect HCWs by specifying that universal precautions are required and (3) to protect patients from risk of infection.

Arguably, there are several weaknesses in the CDC policy. For one, the policy refutes what the public has been advised, i.e., if universal precautions are followed, then the risk of infection is small.<sup>30</sup> The CDC policy segregates and promotes stigmatization of HIV + HCWs. The traditional higher risk groups of HCWs become a basis for determining which HCWs could be singled out and tested.<sup>31</sup>

Another weakness in the CDC policy is its inconsistency with the informed consent doctrine.<sup>32</sup> Informed consent requires HCWs to disclose only significant risks to patients, which is contradictory since universal precautions brings the risk of HIV transmission to almost zero.<sup>33</sup>

Lawrence K. Altman, *U.S. Backs Off on Plan to Restrict Health Workers with AIDS Virus*, N.Y. TIMES, Dec. 3, 1991, at A1, col. 5.

<sup>30</sup> The risk of HIV transmission to an HCW after percutaneous exposure to HIV-infected blood is considerably lower than the risk of HBV transmission after percutaneous exposure to HBeAg-positive blood (03% versus approximately 30%) . . . . Thus, the risk of transmission of HIV from an infected HCW to a patient during an invasive procedure is likely to be proportionately lower than the risk of HBV transmission from an HBeAg- positive HCW to a patient during the same procedure. As with HBV, the relative infectivity of HIV probably varies among individuals and over time for a single individual. Unlike HBV infection, however, there is currently no readily available laboratory test for increased HIV infectivity.

1991 CDC Guidelines, *supra* note 14, at 3.

<sup>31</sup>In *Leckelt v. Board of Comm'rs*, 714 F.Supp. 1377 (E.D. La. 1989), *aff'd*, 909 F.2d 820 (5th Cir. 1990), the public hospital requested that its male nurse employee divulge the results of his HIV test because it was learned that the nurse's roommate had recently been hospitalized with AIDS, and the nurse was believed to be homosexual. The hospital's discharge of the nurse for insubordination was upheld by the Fifth Circuit. While the hospital asserted that the nurse was involved in "invasive procedures" thus posing a risk to his patients, there is some question about the types of procedures the nurse performed. *See generally*, Steven Eisenstat, *An Analysis of the Rationality of Mandatory Testing for the HIV Antibody: Balancing the Governmental Public Health Interests with the Individuals Privacy Interest*, 52 UNIV. PITT. L. REV. 327, 374 (1991). *See also*, McNeil & Spieler, *supra* note 10, (authors represented the public hospital on appeal in *Leckelt* and analyze the various aspects of the case and existing testing policies). It is obvious, too, that Leckelt's homosexuality influenced the hospital's concern that he might be HIV+, thus contradicting anti-homosexuality discrimination policies. Chai R. Feldblum, *Response to Gostin, 'The HIV-Infected Health Care Professional: Public Policy, Discrimination, and Patient Safety'*, 19 Law, Med. & Health Care 134 (1991).

<sup>32</sup>Feldblum, *supra* note 31, 135-36.

<sup>33</sup>Webber, *supra* note 9, at 87 & nn. 181-84. Havesi, *supra* note 15 (Illinois law requires all patients be notified that a health care worker is HIV infected. Americans for a Sound AIDS/HIV Policy are calling for mandatory testing and disclosure to all patients despite degree of risk of

Another flaw in the federal policy centers on the lag time between infection to testing positive, which now has been estimated to be as much as 1 year.<sup>34</sup> With this gap in time, there is uncertainty about when to test oneself, when to approach the expert review panel, and when to discontinue "exposure-prone" "invasive procedures".<sup>35</sup>

The OSHA regulations seek to protect both patients and HCWs from the risk of infection from not only HIV, but also from other highly contagious infections. On the other hand, the CDC Guidelines emphasize only a one-way protection for patients and do not particularly focus on concern for the HCWs who may be infected by their patients.

The reactions to the 1991 CDC Guidelines have been predictably mixed.<sup>36</sup> Patients, if given a choice between a negative HIV HCW versus a positive HIV HCW, will more likely choose the negative HIV HCW, despite the small risk of infection with the use of universal precautions.<sup>37</sup> The mere request for consent by a HCW raises a question of doubt about infection control in the mind of the ordinary patient. Questions posed to consumers signal "a red flag," rather than assure. Such an approach often creates an adversarial relationship, which is a contradiction to the patient-HCW relationship. It is difficult to ignore that even HCWs, with much more education than the average consumer regarding HIV infection controls, are refusing to treat HIV + patients.<sup>38</sup>

being infected with AIDS.); Isaacma *supra* note 8,445-44, nn. 37-39 (90% of Americans believe all health care workers should be required to tell their patients if they are infected and 45% believed that HIV+ doctors should be barred from practice). Arkansas and Missouri require that patients who are HIV+ disclose their status to their HCW. ARK. Rev. STAT 20-15-903 (Supp. 1989) ; Mo. ANN. Stat. 191.656(5) (Vernon Supp. 1990), *cited in*, Webber, *supra* note 9, 90 at a 198.

34. Robert S. Walzer & Francis R. Coughlin *Prevention Dictates HIV Testing of Doctors*, 14 NATL LJ. (Mar. 23, 1992) 12 (Letters to Editor) (discussing the responsibilities of physicians who know their HIV status is positive; arguing that testing costs are "negligible"; citing research of 4-6 weeks on positive conversion).

<sup>35</sup>As an example, a dental hygienist could have a patient scheduled a month in advance, allowing the necessary time for the patient to submit to HIV testing and receive results. By the time of the procedure, it would not be certain if the patient had since become HIV infected. In fact, at the time of the patient's test, it would not be known if the patient had been infected with the virus, but had not yet converted to a positive status. Therefore, the dental hygienist has no absolute security in relying upon a test at any given time period.

36. Larry O. Gostia *The HIV-Infected Health Care Professional: Public Policy, Discrimination, and Patient Safety*, 18 Law, MED. & HEALTH CARE 303 (1991); Feldblum. *supra* note 31; Gross, *supra* note 15; Hevesi, *supra* note 15 (New York adopted a policy differing from CDC by not requiring HIV+ HCWs to divulge their status).

37. Barnes, *supra* note 11, at 311 (survey shows over 55% would switch if their physicians had AIDS or HIV+).

38. Prejudice by HCWs against patients continues to be documented. Noguchi & Klatt *supra* note 7, 81. Several HCWs have explained that their avoidance is based upon fear and the risk involved for someone who will die anyway. Ficarra, *supra* note 9, 97.

## II. TESTING IS THE TOUCHSTONE

Since testing reveals the secrecy of one's HIV status, the purpose of testing is a primary focus when analyzing the federal and state policies that affect HCWs and patients who want to maintain the secrecy of their HIV status. Whether a person to be tested is a HCW employee, a non-HCW employee, or a patient takes on various dimensions. If the person to be tested is in the role of an employee, then the next step to determine is whether or not the employee is a HCW. If the employee is a HCW, then the OSHA and CDC policies usually apply.<sup>39</sup>

For any employee, whether HCW or non-HCW, additional employment laws can conflict with the CDC and OSHA policies, since the employment laws applying to HIV infected workers have struggled to maintain a no distinction approach, whereas the CDC policy singles out a HIV + HCW.

There are several expressed and implied motives for allowing testing for HIV antibodies in federal and state policies, as applied to HCWs and patients.<sup>40</sup> Some of these purposes include:

- (1) Testing for infection control;
- (2) Testing for bona fide employment qualification (BFOQ);
- (3) Testing for medical diagnostic and treatment purposes;
- (4) Testing for insurance benefits; and
- (5) Testing by court orders for victims of certain crimes.

The underlying motives for these listed purposes appear more and less rational depending upon their application to a HCW or to a patient. However, what is also apparent as the motives are examined is that there are some conflicts that cannot be solved by legislative or judicial cures alone, but recognize the need for solutions that provide security from the risk of infection, yet protect the necessary confidentiality of both HCWs and their patients.

Competing with the rationalizations in support of testing are issues of consent, privacy, and confidentiality.<sup>41</sup> A strong argument can be made that it is not the testing that complicates this area, but rather it is the release of testing results that causes concern. If testing is performed, but only revealed to the person tested, then the anxiety associated with stigmatization may be

<sup>39</sup>New regulations enlarge OSHA's jurisdiction by extending to employees who have "occupational exposure," instead of on the basis of their location in a health care facility. Webber, *supra* note 9, 89-90, n. 192, n. 194.

<sup>40</sup>There are several reasons for opposing mandatory or routine testing. Feldblum, *supra* note 31, 139, n. 22.

<sup>41</sup>Hirsch, *supra* note 21, 27; Rennert, *supra* note 7; REPORT OF THE NATIONAL COMMN on Acquired Immune Deficiency Syndrome, America Uving With AIDS 127-8 (1991); ABA AIDS Coordinating Comm., AIDS: THE LEGAL ISSUES 103 (1988).

reduced. Closer inspection of the claimed testing motives reveal that the original motive does not always match the ultimate use of the test. For example, a test may be required under the guise of infection control, yet used to deny services to a HTV+ patient.<sup>42</sup> Stated testing purposes can foster misuse of the testing results. Therefore, confidentiality statutes are extremely significant. Even if the testing is performed, and the results are to remain confidential, the manner in which the test results are physically stored is critical.

At least 35 states have HIV specific testing statutes that spell out the procedures for consent and confidentiality.<sup>43</sup> One source of potential conflict to address in each state statute is the infectious disease reporting act. Some states have defined HIV + carriers to be infectious carriers for purposes of the reporting acts; others have not. Even if the HTV carrier issue is addressed, there are federal policies that add contradictions.

In this abstracted manuscript, the authors discuss the testing exceptions claimed for infection control and BFOQ and compare the federal and state policies to reveal certain unresolved conflicts.

To compare federal and state policies concerning HIV for this manuscript, Texas has been chosen as an example. Texas is one of the largest states with a correlative population of HCWs because of its many medical facilities. Texas also codified its version of the CDC guidelines, which in part, exemplifies the problems that can occur when new laws are added to existing laws.

### III. TESTING FOR THE PURPOSE OF INFECTION CONTROL

If the stated purpose for testing is for infection control, the next step in examining the testing statute is to determine the persons who may be tested and the person with the authority to release the test results. With the immediate concern about infection control of HIV in the health care setting, the following vignettes are used to exemplify the contradictory applications of several testing statutes under the Texas and federal policies.

- (A) KAREN IS A DENTAL HYGIENIST EMPLOYED BY A VETERANS HOSPITAL IN TEXAS; or

<sup>42</sup>See, e.g., *Doe v. Kahala Dental Group*, 808 P.2d 1276 (He. 1991) discussed *infra* at VI. "

<sup>43</sup>See, e.g., CAL. H&S 199.22 (West 1990 Supp.); FLA. STAT. ANN. 381.609(3)(a) (West Supp. 1990) ; N.Y. Pub. HEALTH LAW sec. 2783 (McKinney Supp. 1990); 35 Pa. CONS. STATS ANN. sec. 7605 (Supp. 1991); Tx. HEALTH & SAFETY CODE ANN. sec. 81.102 (Vernon 1990). See Noguchi & Klatt, *supra* note 7, 78; Webber, *supra* note 9, at 92, n. 203; McNeil & Spieler, *supra* note 10, at 1067-68.

- (B) KAREN IS AN OB-GYN PHYSICIAN IN PRIVATE PRACTICE WHO HAS HOSPITAL PRIVILEGES AT THREE AREA HOSPITALS WHICH RECEIVE FEDERAL, STATE, AND NO GOVERNMENT FUNDING, RESPECTIVELY, IN TEXAS. KAREN IS ALSO A MEMBER OF AN INFECTION CONTROL COMMITTEE.

Like many other states, no one in Texas can, as a general rule, require another person be tested for HIV antibodies.<sup>44</sup> Like the OSHA and the CDC Guidelines, Texas does not "require the testing of health care workers."<sup>45</sup> However, like all existing rules, there are certain exceptions. The expressed exceptions for permitting a test in Texas are for (1) victims of certain sexual crimes (2) insurance testing (3) certain patient medical procedures (4) necessary tests for management of incarcerated youths and (5) BFOQ.<sup>46</sup> In Texas, testing results are defined to include both negative and positive HIV outcomes.<sup>47</sup>

There are three specific provisions in Texas that permit testing for the stated purpose of infection control in the health care setting: one allows testing prior to a potential exposure and the other two allow testing after potential exposures. There are two distinctions to address in each of the statutes. The first is the difference between initiating a test and revealing a test that has already been conducted. In Texas law, once the test has been performed, a variety of persons are authorized to know the results. For one example, a test result can be furnished to the "medical personnel to the extent necessary in a medical emergency to protect the health or life of the person identified in the information."<sup>48</sup> If Karen's patient is about to undergo an emergency, then Karen can learn the results of her patient's HIV test, if medically necessary for her patient. The other distinction is the primary, intended beneficiary of allowing the testing, it may be for the patient or for the HCW.

If Karen has no test result from her patient, she can nevertheless have her patient tested under certain circumstances. One statutory provision permits Karen to test her patient, without his/her consent, if the patient is about to undergo a medical procedure.<sup>49</sup> Specifically, Texas law allows the

<sup>44</sup>Tx. HEALTH & SAFETY CODE sec. 81.102 (Vernon Supp. 1992).

<sup>45</sup>Tx. Health & Safety Code sec. 85.206(4) (Vernon Supp. 1992).

46.81.102(a)(4)(A) & (b). Another curiously worded exception allows a test if "(4) the medical procedure or test is necessary ... (C) in relation to a particular person under this chapter."

81.102(a)(4)(C).

<sup>47</sup>81.101(5).

48.81.046(c)(5).

<sup>49</sup>81.102(a)(3).

patient to be tested if Karen could be exposed to HIV or AIDS and there is sufficient time to test and receive the results.

There are several obvious inconsistencies with the stated purpose and the application of this pre-procedure testing statute. For one, Karen would either have to suspect that her patient is HIV+ or else she would have to know already that her patient is HIV+, in which case Karen would not need to test her patient.

Perhaps Karen knows that her patient's sexual partner recently died from AIDS. Karen would be acting inconsistently with both federal and Texas policies, if she is testing for infection control, since OSHA requires that she presume all of her patients are HIV+. CDC, OSHA, and Texas specify that Karen use universal precautions to avoid potential HIV transmission, either to herself or to her patients. Therefore, the Texas exception to testing does not serve the purpose intended, that is, to manage infection. All it seems designed to do is to allow Karen the privilege of knowing her patient's HIV status.

Perhaps Karen would like to know whether her patient is HIV+ because she is pregnant and wants to avoid any risk, however small, to her unborn child. Under federal law, this will serve Karen no valid purpose because any request she would lodge to be relieved from patient duty to those who are HIV + is in violation of both the federal anti-pregnancy discrimination law and the holding in Johnson Controls, which both ban singling out pregnant workers on the basis of pregnancy alone.<sup>30</sup>

Karen's attempted refusal to serve her HIV+ patients is also in violation of her patient's several protected rights, including the Americans with Disabilities Act, which forbids public and private service providers from discriminating in the offer of services to AIDS/HIV + patients.<sup>51</sup> Moreover, Karen is not acting consistently with her own professional ethics, which require that HIV+/AIDS patients be treated without regard to their medical infection.<sup>52</sup>

Another inconsistency in the stated purpose of the Texas testing provision is Karen's ability to test her patient without his/her consent through a general consent form.<sup>53</sup> At first glance, this provision may not appear to be an issue. The stated purpose of testing her patient is for infection control, yet

<sup>50</sup>International Union v. Johnson Controls, 111 S. Ct. 1196 (1991). The Pregnancy Discrimination Act of 1978, amending Title VII. 29 C.F.R. 1604.10.

<sup>51</sup>Section 504 of the Rehabilitation Act of 1973, 29 U.S.C. secs. 701-796 (1992)). Under the Americans with Disabilities Act of 1990, a "professional office of a health care provider is prohibited from discriminating against any disabled person, which includes people with AIDS or HTV+. the Guide to American LAW Supplement 1991, AIDS 5 (West 1991)(citing Pub. L No. 101-336, 104 Stat. 327, codified in Titles 42, 47 & 29). But see, *Leckelt*, supra note 31.

<sup>52</sup>See, e.g., ADA PRINCIPLES OF ETHICS, Advisory Op. 1-A; AMERICAN DENTAL HYGIENISTS ASSOCIATION, PRINCIPLES 2-88.

<sup>53</sup>Tx. HEALTH & SAFETY CODE 81.105.

the Texas law limits the ultimate test result for diagnostic purposes or if related directly to medical treatment.<sup>54</sup> Karen may assert that she misunderstood the purposes for which she could use a general consent form to obtain the HIV status of her patient, or it may be that Karen purposefully wanted to know the patient's HIV status without requiring a specific consent form from the patient. Karen, nevertheless, has achieved her ultimate motive in obtaining the test result, while arguably misusing the consent form and stated purpose of the statute. Thus, the Texas statute allows Karen to test her patient for HIV without the patient's knowledge simply by using a general consent form, for the express purpose of protecting HCWs, as Karen, against possible HIV infection. It is paradoxical that the test can be performed for one reason, yet its result limited for another use.

Testing her patient has now placed Karen in the midst of several dilemmas, in the event her patient is HIV+. If Karen decides to inform her patient, then she activates the Texas mandate for post-test counseling.<sup>55</sup> Karen has also triggered the Texas Communicable Disease Act, which requires her to report her patient as an infectious carrier.<sup>56</sup>

Every state requires that certain diseases be reported to the designated health authority.<sup>57</sup> Texas likewise requires dentists or other professional health care practitioners to report any patient "that has or is suspected of having a reportable disease."<sup>58</sup> HIV is specifically designated to be a communicable disease under the Texas Communicable Disease Act. The act does not give Karen the discretion, but rather it requires her to report, even on a suspicion.<sup>59</sup> In fact, even prior to the test, Karen's initial suspicions leading to her desire to know her patient's HIV status were probably sufficient for her to make a report without awaiting a test confirmation. The Texas act specifies a wide variety of persons, outside of the health care setting, who must comply with the act's reporting procedures; these include any "health professional," any owner or manager of a restaurant or other food handling facility.®

Another bothersome aspect of Karen's action in testing her patient is the potential consequence for the patient's insurer to realize that a test for HIV was performed on an insured and to use the results adversely to the

54.81.106.

55.No positive result can be revealed unless immediate face-to-face counseling is offered. 81.109.

56.TEX. HEALTH & SAFETY CODE ANN. chap. 81 (Vernon Supp. 1992) (secs. 81.041-81.052 specifically govern the reports of communicable diseases).

<sup>57</sup>Hirsch, *supra* note 21, 24. Mandatory reporting is an established exception to the confidentiality privilege between a doctor and patient. *Id.*

58.81.042(b).

<sup>59</sup>One provision actually encourages suspicions of infectious school children 81 042(c)

60.81.042(e)(1)-(10).

patient's medical and other coverage. The test result can be revealed to an insurance company.<sup>61</sup>

Another inconsistency is the prerequisite that there be sufficient time to receive the test result prior to the expected medical procedure. Conceivably, under a general request form, as is used for other pre-admission tests, Karen's patient could be tested, as before a caesarian.

The second Texas statute that specifically authorizes a test for HIV applies to any law enforcement officer, fire fighter, emergency medical employee, paramedic, or correctional officer.<sup>62</sup> These personnel can request that another person (patient) be tested if there has been a job-related exposure and, most significantly, the testing applies to a post-exposure situation. However, the request can only be made, if by sworn affidavit, the emergency person believes (s)he was exposed to HIV. If the suspected carrier refuses to be tested, then the matter must go before a court to be decided, and the procedures are detailed. This places the emergency personnel in ,the dilemma of making assumptions about the potential HIV carrier, such as whether (s)he is a member of a high risk group, which may or may not be a justifiable assumption. The worker is also risking loss of complete privacy and confidentiality when the potential carrier refuses to be tested, since the statute requires court action in that event.

The emphasis in the second testing statute, as pertains to the claimed purpose of testing for infection control, is that it contemplates giving information to the emergency HCW who may have been infected by the patient. The third provision under Texas law is similar to the second one, in that both deal with occupational exposures.<sup>63</sup> Whereas the second provision is focused on the transmission of an infectious disease to a HCW, usually an emergency provider, the third provision centers on patient protection. The third testing provision is modeled after the 1991 CDC Guidelines, which are specifically designed to protect patients from HIV infected HCWs.<sup>64</sup> Unlike the second provision, under the third act, Karen can test her patient without his/her specific consent, but any identifying information must be destroyed after Karen is notified.<sup>65</sup> This caveat would seem to contradict the reporting mandate of the Texas Communicable Disease Act.

<sup>61</sup>In Texas, insurance companies may generally request that applicants submit to HTV tests. 81.102(a)(2); TEX. Rev. crv. STAX ANN. art. 21.21-4 (Vernon Supp. 1992). However, group insurance plans may not exclude or deny coverage for AIDS and related conditions. *Id.* art. 3.51-<sup>6</sup>(3C). *See, Golden Rules Ins. Co. v. Smith, NATL LJ., June 15, 1992, at 6, col. 1 (D. Tx. May 26, 1992) (health insurance company could not deny coverage to applicant who failed to report he had tested HIV+).*

<sup>62</sup>81.050.

<sup>63</sup>81.102(a)(4)(D).

<sup>64</sup>Texas has adopted the essence of the 1991 CDC Guidelines, with some changes. The Texas 'quivalent of the 1991 CDC Guidelines became effective on September 1, 1991.

<sup>65</sup>81.107.

While mandatory testing of HCWs is not required in Texas nor under the CDC Guidelines, it is implicitly recommended in order for a HCW, such as Karen, to know her HIV status.<sup>66</sup> Both Texas and the CDC Guidelines recommend that HCWs "who perform exposure-prone procedures should know their HTV antibody status."<sup>67</sup> However, because Karen may not be aware of possible infection from a patient, she can only know her actual status by testing.<sup>68</sup> In essence, the Texas CDC Guidelines, while not requiring an employer to institute mandatory testing, nevertheless support mandatory testing by the HCW-employee him/herself. Karen can submit to testing, if she desires, although she cannot be required to test herself under any of the occupational exposure acts.<sup>69</sup> However, Karen should promptly test herself after an accidental exposure to preserve her right to collect workers compensation.<sup>70</sup> Texas provides she must submit to a baseline test within 10 days after the accidental exposure in order to later claim occupational infection and benefits.<sup>71</sup>

Following the CDC Guidelines, the Texas provision allows Karen, if she is HIV+, to continue "exposure prone" invasive procedures, only after she has first obtained the consent of both an expert review panel and her patient.<sup>72</sup> The term "exposure prone" is not defined by the CDC Guidelines, but the Texas statute attempts to clarify what an "exposure-prone" procedure is.<sup>73</sup> Confusion remains, however, for HCWs in differing fields as to whether procedures with unpredictable potentials for bleeding, such as dental cleaning, would be included under this section.<sup>74</sup>

<sup>66</sup>See generally, Michael L. Closen, *A Call for Mandatory HIV Testing and Restriction of Certain Health Care Professionals*, 9 ST. LOUIS U. PUB. L. REV. 421 (1990).

<sup>67</sup>1991 CDC Guidelines, *supra* note 14, at 5.

<sup>68</sup>See, e.g., *Doe v. Knights of Columbus*, NATL LJ., June 15, 1992, at 6, col.1 (Sonora County V.1182566 June 4, 1992) (nurse who was not aware that she had been infected through occupational exposure sued insurance company for negligent counseling and delivery of her HIV test results).

69.81.102(c). A person who is exposed occupationally to potential HIV may not be required to be tested. 81.050(k).

<sup>70</sup>81.050(j).

<sup>71</sup>*Id.*

<sup>72</sup>85.204 85.204(c). It should be emphasized that both CDC and Texas are sensitive to the plight of the infected HCW and specify that the infected HCW should be allowed to continue modified work.

<sup>73</sup>Exposure-prone procedure' means a specific invasive procedure that poses a direct and significant risk of transmission" to be identified by the health professionals and facilities. 85.202(1).

<sup>74</sup>Subsequent to the CDC guidelines, the American Dental Association's Board of Trustees convened a Task Force to clarify their understanding about the term "exposure-prone procedures." ADA, Report of the Task Force on Invasive Procedures, Aug. 1991, at B-1, pp. 1900-1902. "[T]he Task Force suggests that the term ' exposure-prone procedure' be used to distinguish oral surgical, endodontic surgical and periodontic surgical procedures from other invasive dental procedures," because these procedures cause significant patient bleeding through the use of sharps and/or physical force. *Id.* at B-3, p. 1903.

Even if she is HIV+, Karen can continue under Texas law to perform non-exposure prone invasive procedures, so long as she adheres to the universal precautions.<sup>75</sup> Karen may desire to remain secretive so as not to risk loss of job opportunities, however, her secrecy can be jeopardized under the employer's infection control policy. Unlike the federal policies, which rely upon Karen voluntarily presenting herself to an expert review panel, it is a criminal offense in Texas for Karen's employer not to report her if she is a suspected carrier of an infectious disease based. A health care employer's usual policy for reporting all needle sticks or other occupational punctures can conflict with the intended federal policies to allow voluntary disclosure of HIV + status by HCWs.<sup>76</sup> That a HCWs employer could force the HCW to limit or terminate his/her practice altogether was not an expressed intention in the CDC Guidelines and, furthermore, the primary protection of the antidiscrimination laws for HIV+/AIDS employees is reversed for HCWs by activating the use of suspicions alone, as exemplified in the Texas Communicable Disease Act.

Another unclear point about the Texas Guidelines is that they do not require that the patient be notified about the occupational exposure. Many medical facilities have faced the dilemma of whether to notify patients about their HCWs HIV infection and/or death from AIDS. Resulting anxiety could be reduced, if patients were advised in advance about their HCWs status, but this procedure disregards the HCWs confidentiality and desire to remain secretive about their HIV status.<sup>77</sup> If Karen must change her job responsibilities as part of her compliance with the decision of the expert review panel, she risks losing confidentiality since her employer and colleagues could become aware of the situation.

The mere coincidence of an accidental exchange of blood activates vital decisions affecting Karen, her spouse, her unborn child, her employer, who is obligated under federal and state laws to follow additional procedures, and has altered her patient's privacy as well.

Thus, the three Texas exceptions to the general mandate against testing for the claimed purpose of infection present conflicts when the motives are more closely compared to existing employer policies and to stated federal policies. Since the Bergalis tragedy, the focus was upon safeguarding patients from infected HCWs, but there were existing Texas laws to allow HCWs to test patients for the HCWs safety. The conflicts have occurred at the state level because of the immediate emphasis given to the patient.

<sup>75</sup>Texas mandates the OSHA universal precautions. 85.203.

<sup>76</sup>OSHA requires that the source patients be informed after an occupational exposure and that records be kept on needle sticks and other punctures. Webber, *supra* note 9, at 91-92, nn. 200-

<sup>77</sup>Richard W. Blumberg, Jack E. Burkhalter, & Bessie Garrett, *When a Health Care Worker is HIV-positive: Response to a Crisis*, 9 VA PRACTITIONER 59, 61 (Aug. 1992).

V. TESTING FOR THE BFOQ PURPOSE

At this juncture, the BFOQ exception to testing for HIV in Texas can be triggered to allow Karen's employer to test her for HTV. Texas mandated that the BFOQ test be "reasonably related to the satisfactory performance of the duties of the job" and that there be "reasonable cause for believing that a person of the excluded group would be unable to perform satisfactorily the duties of the job with safety."<sup>78</sup> Karen's employer could justify implementing routine testing or specific testing for infection control. The employer has the burden of showing that there is not a less discriminatory means of satisfying the occupational qualification.<sup>79</sup>

Despite the increased number of federal and state laws protecting employees from discrimination on the basis of being HIV+/AIDS, this Texas provision, as applied specifically to the HCW, creates many conflicts. One contradiction is in the provision that clearly states that an employee, such as Karen, who may have been infected by a reportable disease on the job cannot be made to take the test.<sup>80</sup> But, the BFOQ exception would allow a health care employer to justify testing HCWs periodically in order to comply with OSHA and Texas state guidelines.<sup>81</sup> A private dentist may claim a relatively greater right to test all employees, given public concern over the Kimberly Bergalis incident.

VI. ADDITIONAL EXAMPLES OF CONFLICTING STATE AND FEDERAL POLICIES

A. *Patient Testing*

One example of an alleged patient discrimination in a pre-procedure incident occurred in *Doe v. Kahala Dental Group*.<sup>82</sup> The Hawaii Supreme Court ruled that a private dentist office could refuse to perform dental work on a patient who refused to be tested for HTV. The patient claimed he was handicapped under the Hawaii law equivalent to the Rehabilitation Act, but the court disagreed.<sup>83</sup>

**78. 81.101 (3)(A)-(B).**

79. 81.102(a)(4)(A) & (b).

<sup>80</sup>See *supra* note 69.

<sup>81</sup>See generally, McNeil & Spieler, *supra* note 10.

<sup>82</sup>808 P.2d 1276.

<sup>83</sup>"Even if an asymptomatic HIV viral infection is a handicap under the statute [Hawaii HRS sec.489 furnish of public accommodations can not discriminate against a person with or believed to have a handicap], a question which is certainly not free from doubt \_\_\_\_\_ *Id.* at 1277. The Texas Commission on Human Rights Act specifically excludes as a disability a person with AIDS or who is HIV+. TEX. REV. CRV. STAT. ANN. art. 5221k. sec. 2.01(4)(A) & (B) (Vernon Supp. 1992).

This case presents two problems with the court's logic: if the dental clinic were following "universal precautions," as per OSHA, then it should not have had concern for the patient's HIV status. Although the court stated that the plaintiff lost his case because there was no discrimination, the clinic probably did suspect the patient had AIDS or was HTV+.

The most bothersome part in the court's decision is its clear indication that an HIV patient would not be protected from discrimination by a private dentist's office under state law.<sup>84</sup> In the future, Hawaiian patients may be required to reveal their HIV status or be symptomatic with AIDS before being able to assert legal protection.

### B. HCW Testing

Leckelt v. Board of Comm'rs<sup>85</sup>: Although the 1987 CDC Guidelines, instead of the 1991 CDC Guidelines, were used in Doe v. Washington,<sup>86</sup> the case is nevertheless instructive as an example of the conflicts with the confidentiality of testing HCWs under federal policy. The plaintiff, a dental student, discovered in 1988 that he was HIV+. The dental school decided that the student would not be allowed to continue because graduation requirements included performing certain invasive procedures that carry a risk of HIV transmission.<sup>57</sup>

The court correctly referred to the four factors outlined in School Bd. of Nassau County v. Arline,<sup>88</sup> but ultimately, the Bergalis incident influenced the court's decision.

Although since the filing of this lawsuit a number of cases have been publicized that indicate the realistic possibility of transmission of HIV from an infected health care worker to a patient, there is no nationwide consensus on the precise probability that an HIV-infected dental student will transmit HIV to a patient.<sup>89</sup>

84. The court stated that there was no discrimination because the plaintiff-patient had not alleged that he was refused services because of a handicap, but rather that he had been refused because he would not furnish information as to his physical condition.

<sup>85</sup> See *supra* note 31.

<sup>86</sup> 780 F.Supp. 628 (D. Mo. 1991).

<sup>87</sup> The dental school offered the student admission to another related medical program, which he refused. The dental school even considered allowing him to perform in the HIV-infect patients clinic, which proved not to be feasible.

<sup>88</sup> 480 U.S. 273 (1987).

<sup>89</sup> *Id.* at 632. The court refers to the CDC report of Ms. Bergalis' dentist. *Id.* 633, at n. 8.

VII. CONCLUSIONS

AIDS and HIV have been compared to leprosy, TB, and Alzheimer's. There are obvious epidemiological differences in the diseases. For one, Alzheimer's is not infectious. For another, TB is not 100% fatal. But what each has in common is the stigma. When a person is diagnosed with Alzheimer's, there is generally immediate compassion. Alzheimer's, like AIDS, is fatal. Like AIDS, there is no cure. Unlike AIDS, there is no fear of contagion from Alzheimer's. Unlike AIDS, there has yet to be a definitive social stigma attached to the mere diagnosis. To be sure, there is a fear of a person with progressed Alzheimer's. But, if a person with AIDS is compared to a person with Alzheimer's, there is less prejudice against the Alzheimer's victim.<sup>90</sup> In fact, victim rarely is a label attached to the AIDS patient.

With this inadequate comparison in mind, the authors conclude that while education is the key to a better tolerance of AIDS victims, continued attention to legislative and judicial policy is also necessary. Legislating public attitude is a sensitive and volatile matter. One must always be aware that the laws enacted to cure one ill can unexpectedly create another. In the meanwhile, however, the medical and legal and social policy makers must continue to work together and not fall prey to immediate solutions driven solely by the desire to assuage public fears.

As demonstrated above, conflicts between the desire to assuage the public's fears regarding the safety of the health care system, while at the same time protecting the rights of health care workers have led to a confusing array of legal protections. The authors propose no simple panacea to the AIDS pandemic. It appears that since stigmatization and confidentiality are at the heart of the problem that one approach may be to require all people to be tested and to treat AIDS and HIV as any other infectious disease.

<sup>90</sup> *Accord, Hirsch, supra* note 22, at 28.